MPI Generali Insurans Berhad
Reg No : 197301001061 (14730-X)

Head Office : 8th Floor, Menara Multi-Purpose, Capital Square, 8, Jalan Munshi Abdullah, 50100 Kuala Lumpur, P.O. Box 10122, 50704 Kuala Lumpur, Malaysia.
P +603 2034 9888 F +603 2694 5758, +603 2694 5759 mpigenerali.com

DISCHARGE MEDICAL REPORT FORM

The issue of this form is NOT an admission of liability on the part of the Company.
Pengeluaran borang ini tidak bermakna tanggungan pihak Syarikat telah diakui.

SECTION I – To be completed by the Insured / Claimant (IN BLOCK LETTERS)
SEKSYEN I – Untuk diisi oleh Pihak Diinsuranskan / Pihak Menuntut (DALAM HURUF BESAR)

	NRIC No. / *No. K/P*	Policy No. / *No. Polisi*

Claimant (other than the Insured) / *Pihak Menuntut (selain daripada Pihak Diinsuranskan)*	Claimant / *Pihak Menuntut:* ☐ Self / *Diri Sendiri* ☐ Spouse / *Pasangan* ☐ Child / *Anak*	NRIC No. / No. K/P (if applicable / *jika berkaitan*)

Birth Date / *Tarikh Lahir*	Age / *Umur*	Sex / *Jantina*	Race / Bangsa	Religion / Agama
☐ (dd) *Tarikh* ☐ (mm) *Bulan* ☐ (yy) *Tahun*		☐ Male / *Lelaki* ☐ Female / *Perempuan*		

Marital Status / *Status Perkahwinan*	Occupation / *Pekerjaan*	Date of Employement / *Tarikh Penggajian*

Employers Name, Address & Telephone No. / *Nama, Alamat & No Telefon Majikan (For Group Policy only)*	Date patient joined the Insurance Scheme / *Tarikh pesakit menyertai skim Insuran*	Insurance's Plan No. / *No Pelan Insuran*

Claims Cheque should be made payable to
☐ Employer/Insured ☐ Employee/Insured ☐ Hospital

Type of Claim (Please tick where applicable) / *Jenis Tuntutan (Sila tandakan yang berkaitan)*
☐ Hospitalisation / *Dimasukkan ke hospital* ☐ Outpatient / *Pesakit Luar* ☐ Accident / *Kemalangan*

If injuries are due to accident, please describe how the accident occurred /
Jika kecederaan disebabkan oleh kemalangan, sila terangkan bagaimana kemalangan berlaku.

……

……

Details of other insurance policies, Socso, Workmen's Compensation and others: (please use a separate sheet if necessary)
Butir-Butir insurans lain, Perkeso, Insurans Pampasan Pekerja dan lain-lain:

Policy Type / *Jenis Polisi*	Period of Cover / *Tempoh Perlindungan*	Insurance Company / *Syarikat Insurans*	Policy No. / *No. Polisi*

AUTHORISATION TO PHYSICIAN, HOSPITAL OR CLINIC TO RELEASE INFORMATION & DOCUMENTS /
MEMBERI KEBENARAN KEPADA DOKTOR PERUBATAN, HOSPITAL ATAU KLINIK UNTUK MEMBERI MAKLUMAT & DOKUMEN

I hereby authorise any physician, medical practitioner, hospital or clinic by whom or where I have / my ward has been observed or treated, to give full particulars about my / ward's health including my / ward's whole medical history in respect of this hospitalisation / surgery, to the above insurance company. /

Saya dengan ini memberi kebenaran kepada doktor perubatan, pengamal perubatan, hospital atau klinik yang merawat saya / tanggungan saya untuk memberi maklumat-maklumat lengkap berhubung dengan riwayat kesihatan saya / tanggungan saya termasuk latarbelakang penuh perubatan saya/tanggungan saya semasa dimasukkan di hospital / menjalani pembedahan kepada syarikat insurans.

……	……	……
Signature of Patient / *Tandatangan Pesakit*	Signature of Insured & Company Chop / *Tandatangan Pihak Diinsuranskan/Pihak Menuntut & Chop Syarikat*	Date / Tarikh

SECTION II – To be completed by the Attending Doctor (IN BLOCK LETTERS) **MRN No:**

Name of Hospital and Address

Name of Patient | NRIC No.

Date and Time of Admission

☐ (dd) ☐ (mm) ☐ (yy) ☐ (hrs)

Date and Time of Discharge

☐ (dd) ☐ (mm) ☐ (yy) ☐ (hrs)

Name of Referring Doctor and Address

Admitting Doctor | Attending Doctors | Speciality

1a. Diagnosis / ICD Coding

1b. Cause and Pathology (if applicable) of the above diagnosis

4a. Please ✓ Nature of Treatment and Investigation:

☐ OPERATION ☐ PHYSIOTHERAPY DIETARY
☐ COUNSELLING ☐ MEDICATIONS
☐ X-RAY ☐ BLOOD TESTS
☐ OTHERS *(Please provide details)*

……

……

4b. Please state the surgical procedures performed.
If more than one procedure was involved, please state Type of Procedures performed:

TYPE	DATE	NAME OF DOCTOR
i.		
ii.		
iii.		

2a. When did patient first consult you for this condition?

☐ (dd) ☐ (mm) ☐ (yy)

2b. Was the patient previously treated for this condition?

☐ No ☐ Yes, please provide details and when

☐ (dd) ☐ (mm) ☐ (yy)

……

……

……

2c. How long in your professional opinion has the condition existed?

☐ (dd) ☐ (mm) ☐ (yy)

4c. Other medical conditions present?

……

Since (dd mm yy)

……

……

Since (dd mm yy)

……

3. Any possibility of a relapse?

☐ Yes ☐ No

5. Was the condition

☐ congenital ☐ nervous ☐ mental

6. Was the patient pregnant at the time of hospitalisation? (For Females Only)

☐ No ☐ Yes, ……months

7. If the hospitalisation was due to accident, please indicate date / time of accident:

☐ (dd) ☐ (mm) ☐ (yy) ☐ (hrs)

8. Discharge / Follow-up instructions

…… …… ……

Signature and Name of Attending Doctor | Hospital Stamp | Date